ADMINISTRATION OF MENTAL HEALTH PROGRAMS IN SAN DIEGO COUNTY

SYNOPSIS

The background supporting how the 2000-2001 San Diego County Grand Jury analyzed the state of mental health programs in San Diego County, as well as a brief historical review of the attitudes and treatment of mental illness over the past 200 years is included in this report. Particular emphasis is given to the period since the passage of the Lanterman-Petris-Short (LPS) Act by the California Legislature in 1968. This act closed a number of in-patient psychiatric beds. The responsibility for the majority of the mentally ill was transferred from the state to the counties and communities. Special reference is made to the fiscal and administrative effect this act had on San Diego County. A survey of many workers in the field was made as to what problems existed and what possible solutions could be offered.

The problems peculiar to San Diego County are listed, together with recommendations for long-term and short-term mitigation. They are similar to the statewide findings enumerated by the recently published report of the Little Hoover Commission.

The principal problem identified by the Grand Jury was under-funding. This, in turn, led to insufficient personnel, limited treatment facilities and the incarceration of too many mentally ill at great expense. In short, the mentally ill are underserved in this county. The multiplicity of funding sources and fragmentation of administration has led to inefficient use of funds and increased overhead expenses.

New concepts such as the pharmacological treatment of mental disease, and the need for integrated comprehensive case management are highlighted.

The need for early recognition by the school system is stressed. Public attitudes and other factors preventing full use of existing programs are explained.

There is a lack of leadership and continuity of policy. There is no sophisticated Medical Information System in place to properly evaluate existing programs and justify grants.

There are many capable, devoted and knowledgeable professionals in this county attempting to serve the mentally ill under trying circumstances. Their advice is not always sought.

The Psychiatric Emergency Response Team (PERT) and Homeless Outreach Teams (HOT) the Serial Inebriate Program (SIP) as well as the integrated case management of children are steps in the right direction.

Given the severe fiscal and administrative constraints by state and federal agencies there is much room for improvement but the complaint that "Mental Health in San Diego County is in Shambles" could not be sustained by the Grand Jury.

This report will make several recommendations for improvement in the Administration of the Mental Health System in San Diego County.

BACKGROUND

History relates that there has always been a stigma attached to mental illness. Persons thus afflicted were thought to be possessed by evil spirits or even by the devil himself. They were segregated from the community, persecuted and even burnt at the stake to "exorcise" these demons. The tendency to isolate these unfortunates persisted into the 20th century. Mentally ill patients were hidden in attics or placed into large state-operated hospitals. Families tried to deny the fact that any of their members were mentally ill. Governments provided food and shelter; otherwise these unfortunates were out of sight and, thus, out of the public conscience.

The only treatment available at these institutions was observation, to see that they did not hurt themselves, isolation in padded cells, sedation and cold baths. Once admitted into these institutions and diagnosed, their families and the public forgot them.

In the middle of the 20th century we begin to see the first attempt at treatment, such as psychotherapy, psychoanalysis and electroconvulsive therapy directly focusing on mental illness.

Then the revolutionary discovery that medication could control, improve and even cure mental disease ushered in the era of psycho-pharmaceutical treatment of mental illness.

Since it is the social obligation of government to take care of the mentally ill, this shift in treatment paradigm was not lost on government policy makers. Patients could now be treated as outpatients and the expensive, large government run mental institution was no longer required.

As the need for psychiatric beds decreased in California, the legislature passed the Lanterman-Petris-Short Act of 1968 to provide funds for the humane outpatient treatment of the mentally ill. The act provided that no patient could be committed to a mental institution for longer than 72 hours without evaluation and appropriate referral. The lawmakers were not moved by financial consideration alone. They tried to prevent a situation where a patient was confined to a mental hospital against his will for reasons other than mental disease, for instance, due to pressures from his family or even from the state, as was the case in the USSR.

As a result of the Act, many of the previously hospitalized mental patients were released on the street, a situation with which these patients were unable to cope. They had, for

many years, been sequestered from "normal" life. They had been provided with food, shelter and what little treatment there was available. Now they were confronted with a life for which they were not prepared. They did not have normal survival skills. They were increasingly frustrated and non-compliant with their medication, which up to now had been given to them by nursing personnel. Furthermore, some of these drugs were not instantly effective and took weeks to build up a therapeutic level. The patient became frustrated with the apparent lack of effect. Frustration led to inappropriate drug and alcohol use and eventually to homelessness.

By closing the state-run mental hospitals, the legislature passed responsibility of caring for the mentally ill to the counties along with some funding to cover the costs. The political climate in San Diego County, at the time, was such that the responsible authorities were unwilling to apply for these funds which had, in their view, unacceptable conditions attached.

At first, San Diego County was able to cover the care of the indigent mentally ill, but, as time went on, it became obvious that, compared to other counties (such as Los Angeles and San Francisco), San Diego was grossly under-funded. Other counties had sought state funds much more aggressively no matter what conditions were attached. This made their programs much more flexible and comprehensive. The gradual realization that the severe shortage of state funds had serious implications for addressing the needs of the mentally ill came very late to San Diego County. There was either an inability or a reluctance to make up the shortfall.

The history of San Diego's share of state funds is a very sorry tale. In the 1960s it was the position of the then Director of Health and Human Services (HHS) to deny the existence of the mentally ill among us, to ignore their presence and even to return the proffered monies to the state. This attitude was apparently shared by the then Board of Supervisors. The funds went back to the state and were distributed to other counties who were only too pleased to accept them and to develop some very good services for their own mentally ill. This left San Diego County as 52nd out of 58 counties with regard to funding for mental health programs.

Since then attempts to get the legislature to provide this county with an equitable amount based on the size of its population have failed repeatedly. Finally, a lawsuit by the county against the State Department of Mental Health brought partial, but by no means adequate, relief. San Diego County has been "playing catch-up" ever since.

San Diego County has been in the lead of embracing the concept of managed care. Health Maintenance Organizations (HMOs) were believed to supply medical care in a more efficient, and therefore, more economical, way. By their nature, being for profit, their first responsibility is to their shareholders.

The County Board of Supervisors turned to a private organization to administer mental health services. In a rare moment of unanimity a group of workers in the mental health field prepared a Request for Proposals (RFP) setting out the desired conditions of the

contract. Only four applicants applied and United Behavioral Health (UBH) was by far the most superior applicant on paper and was awarded the contract to administer mental health services for the county for a three year period for a sum of $13 million. Evaluation and management functions of the program were also moved from the County Department of Health and Human Services to the new contractor.

The insertion of an entity, which ran an administrative program for profit, was a new concept to workers in the field. The mental health community resented the changes that were introduced. They claimed that, even though these changes were saving money, they were detrimental to patients' care. San Diego was working with state and federal funding levels which were already far below that of other counties.

One of the ways to mitigate this shortfall was the mandate for UBH to sign up more eligible MediCal recipients through its subcontractors. It was alleged, by some respondents, that UBH did not live up to that obligation of their contract which would have done much to increase the amount of funding available to the County. As a result the then County Director of HHS filed a "Notice of Action" forcing UBH to comply. The contract was extended for only one year and the management and supervisory functions of the program were given back to the county.

Aggravating the mental health situation in San Diego County was the resignation of the Director of HHS and the resignation of the two Directors of Mental Health in quick succession. The permanent Mental Health Director's position has not yet been filled. These vacancies in the top positions have led to a lack of continuum in the field of mental health. It is, therefore, not surprising that the complaint of "Mental Health in San Diego County is in Shambles" has been raised.

The last 200 years have seen marked changes in the diagnosis and treatment of mental illness. Unfortunately, public attitudes toward mental disease have not changed that much over the same period of time. Philosophically, there has been a tendency to drift towards a more holistic approach, a policy that treats the body as a whole. The Surgeon General has used his office to bring about parity between physical and mental health. A great deal of work needs to be done to achieve this ideal state.

But old attitudes remain. The public, the government and even a part of the medical profession continue to treat mental illness as a separate entity. As far as insurance coverage is concerned there is a definite disparity between mental and physical health. San Diego County is no exception.

There is still a persistent stigma attached to the mental patient. This is not only confined to the public but includes a large percentage of the medical community who are untrained or unwilling to handle mental illness. Some physicians are, either by virtue of traditional training, or by a mind-set averse to change and unwilling to realize that mental illness is part of physical illness.

Mental patients are often disruptive and time-consuming and therefore the traditional view is to try to disassociate oneself from them. Many practicing physicians turn to someone else to take care of these patients. This attitude also explains why in the minds of policy makers, the public, and the medical profession, a tendency persists to distinguish mental health from physical health.

Families tend to deny or hide the existence of mental illness among them. Government agencies try to avoid coming to grips with this problem and, in spite of their social responsibility, tend to let someone else handle it or hope that the problem will go away. The mentally ill have no constituency and are not strongly represented in the seats of power. The presence of the homeless on our streets and the multitude of minor offenders, many of them mentally ill, is a constant reminder that we have not solved the problems of those afflicted. Neighborhoods and communities, which could form part of the support system for the mentally ill, wish they would go to another community. They oppose the placement of treatment centers in their part of town.

Most mental disease tends to run in families and is now treatable. This fact, which has not been fully realized by the general public, has important implications for the formulation of public policy. There is, therefore, a great need for the public to be fully informed of these new scientific advances, especially, when the direct and indirect costs (loss of productivity) brought about by untreated mental illness are considered. In the United States, these costs are estimated to be $79 billion annually. Mental diseases, especially depression, are very prevalent in our population. It is time to eliminate the stigma associated with the diagnosis of mental disease. When families accept the diagnosis without shame and arrange for available treatment they can bring the affected patient back toward a productive life.

PROCEDURES

The Grand Jury, when faced with the complaint “Mental Health in San Diego County is in Shambles,” was initially reluctant to take on such a complex and far-reaching issue.

It soon became obvious, however, that the present situation is critical and untenable. The mentally ill have few advocates near the seats of power where policies are made and funding is distributed. Yet, there is a mandated social responsibility of government to take care of them. Someone had to speak out, shed the light of public opinion on the existing problems, and make some suggestion for their improvement.

Is the treatment of mental disease in San Diego County really in shambles? In an effort to obtain a fair and balanced answer to that question the Grand Jury interviewed stakeholders from many different disciplines involved in the care of mental patients. They included public health workers past and present, hospital officials in for profit and not for profit institutions, psychiatrists in private practice, officials of the San Diego County Medical Society, and patient advocates. We asked each what they perceived the problems to be.

It must be remembered that these recommendations for mitigation are merely a summary. They are based on extensive reading of the literature on this subject and research on the Internet.

These recommendations are consistent with the findings of the recently published report of the Little Hoover Commission, "Being There-Making A Commitment to Mental Health," as it pertains to all 58 California counties and point out those which are particular and unique to the situation in San Diego County.

Starting as outsiders, and having no discernable interest other than to make San Diego County a better place to live, the Grand Jury soon became better informed as the study of this problem progressed.

The following documents were reviewed:

HISTORY AND LEGISLATION

"Major Milestones: 43 years of Care and Treatment of the Mentally Ill," Legislative Analyst's Office, March 2, 2000;

"The Lanterman-Petris-Short Act," West's Annotated California Codes, Welfare and Institutions Code, Section 4500 to 5600.000;

AB 1100, California's mental health parity Legislation, 1998;

AB 1913, Workers' Compensation Act, amended, September 1994;

AB 2034, (Steinberg), Mental Health Funding: local grants, September 2000;

SAN DIEGO COUNTY

"County of San Diego, Department of Health Services Statement of Work, Administrative Services Organization," October 21, 1997;

"Statement of Work-Administrative Services Organization for Mental Health Services, Definitions," Contract #43819, October 21, 1997;

"System Redesign Implementation Plan for Adult-Older Adult Mental Health Services" August 1999;

"System Redesign Implementation Plan for Adult-Older Adult Mental Health Services" July 1999;

"Children's Mental Health Services Initiative," October 2000;

"County of San Diego, Health and Human Services Agency Regional Psychosocial Rehabilitation Centers For the North County Mental Health Regions Draft-Statement of Work," December 1999;

"Adult and Older Adult Mental Health Services Provider Resource Manual," August 1999;

"Mental Health and Substance Abuse Treatment Spending Shrinks as Percentage of National Health Care Expenditures," The MEDSTAT Group, August 2000;

"Health and Human Services Agency Payroll Review, County of San Diego," January 2000;

"Homeless Service Profile," January 2000;

"Community Care: Managed Integrated Systems of Care, An Evolved Model for Family Support," 1999;

"Real Homeless Profile, an update on homeless throughout San Diego County and its 18 Cities," August 1999;

"Response to Proposed Questions Regarding the Medi-Cal/Healthy Families Outreach Campaign-Request for Proposal (RFP) No. 97-111933," 1997;

"City of San Diego-Manager's Report, Program to assist special needs of Homeless Population," December 1999;

"County of San Diego, Mental Health Board Roster," July 2000;

"Waiver Concept Paper," June 2000;

"Behavioral Health in San Diego: A Fragile Balance," Hospital Council of San Diego and Imperial Counties, October 1997;

"System Redesign Implementation Plan for Adult-Older Adult Mental Health Services," County of San Diego Health and Human Services Agency, Mental Health Services, August 1999;

"Children's Mental Health Services, Providers Resource Manual," September 2000;

"Who are the Uninsured?" Draft Options Report, October 1999;

"The San Diego Project: Providing Independent Housing and Supportive Services," Richard L. Hough, Ph.D. 1998;

"Adapting Health Care to the County's Most Diverse State," Dr. Robert Ross, 2000;

"San Diego Improving Access to Healthcare Project: Waiver Concept Paper," June 2000;

STATE OF CALIFORNIA

"A Brief Overview of County Programs for Mentally-Indigent Adults in the State of California," The Pick California Project, August 2000;

"Little Hoover Report-Being There; Making a Commitment to Mental Health," November 2000;

"Mental Health Funding in California Counties," 1996-1997;

OTHER STATES

"Oregon Model of Home and Community-based Care," April 27, 1998, Portland Oregon;

NATIONAL

"NAMI's 2000 Annual Convention Summary," June 2000;

"The American Psychiatric Association Capitation Handbook," September 1995;

"Mental Health: A Report of the Surgeon General," 1999;

OTHER READING

"Broken Contract," *Los Angeles Times,* Dan Morian and Julie Marquis, November 1999;

"Mental Health Needs of Traumatized Children," Barbara Ryan, November 2000;

"San Diego Physician," July 1998;

"A Street is Not a Home," Judge Robert C. Coates, 1990;

"A Mental Health Plan That May Fail," Sharon Kalemkiarian and Joseph Mawhinney; 2000;

UNITED BEHAVORIAL HEALTH (UBH)

"United Behavioral Health Contract with Health and Human Services Agency," Contract No. 43819", June 2000;

"UBH San Diego County Mental Health Services ASO Proposal," 1997;

UBH Contract and Amendments 1-7, 1997-2000;

"UBH, San Diego Public Sector Organizational Chart," July 2000.

FACTS

The following problems became apparent and can be divided into two broad categories;

I. PROBLEMS OF THE MENTAL HEALTH SYSTEM IN THE STATE

The Governor ordered an analysis of the State of California's Mental Health System. This was published on November 20, 2000 by the Little Hoover Commission. The purpose of the analysis was to study the quality and availability of mental health services for California's adults. The Commission findings reflect the same problems faced by the mental health community in San Diego County are present statewide. For details the reader is referred to the very comprehensive original document.

II. PROBLEMS OF THE MENTAL HEALTH SYSTEM IN SAN DIEGO COUNTY

A. Finances

- Mental Health, and, indeed physical health, is grossly under-funded compared to other large counties (San Francisco and Los Angeles). The daily MediCal reimbursement for a patient's hospital stay in San Diego County is $365 versus $600 in Los Angeles County.

- San Diego County is 52nd out of 58 counties in the state with regard to funding.

- The proportion of mental health dollars compared to physical health funding is not commensurate with the extent of the problem.

- The county has difficulty retaining psychiatrists of high quality. In fact, many psychiatrists are closing their offices or leaving the county. The job vacated by the last Director of Mental Health has not yet been filled.

- Treatment of the most severely affected patients, in hospital or penal institution, is the most expensive use of the mental health funds. There is little left over for the great many treatable patients who have the best chance of being restored to become self-supporting citizens.

- Allocation of $10 million of tobacco tax money, over time, and the recent grant of $10 million for a 3 year Pilot Program (AB 2034 Steinberg) has, in a small way, partially relieved the severe financial shortfall.

- There are many programs and agencies purporting to help the mentally ill. There is a multitude of funding sources originating from the Federal, State, and County governments, each with their own rules for eligibility. In addition there are funds from private sources and charitable foundations.

- Some funds are categorical, that is, they can be used only for certain categories of illness. In some cases these categories can be waived and the money pooled.

- Following the passage of the LPS Act, funding for the care of the mentally ill was transferred from the state to the counties on a 9:1 ratio (state to county) with an important caveat "if county funds were available". That is to say that, in a poor economic environment, there is less money for the treatment of the mentally ill under the present LPS provision. This wording produces a very unreliable source of funding, a condition which the state legislators are trying to amend.

B. Legislative Representation

- The state, until recently, was in poor financial health. There were only so many dollars to go around. There is a persistent inability of local representatives, assembly members, senators and lobbyists in Sacramento to bring San Diego County, with its 2.8 million citizens, to a parity of funding with other counties having large urban centers. Giving San Diego County more would have meant that other counties would have had less. That is a political fact.

C. UBH and Managed Care

- The Board of Supervisors was mandated by the state to reorganize the delivery of the public mental health system using the Managed Care model.

- United Behavioral Health (UBH) was the management system chosen from four applicants to the county's Request for Proposal (RFP). It

presented the best proposal and its contract was let for three years to manage the mental health care system. Childrens' Mental Health and Drug Dependency Program were excluded. After an initial "rocky start" UBH is now working within the parameters laid down in the contract which ends on June 30, 2001.

- Some problems resulted from individual psychiatrists and health care workers being unfamiliar or even philosophically opposed to working within the managed care environment or, for that matter, a for-profit company where a large percentage of the money goes to management or consultants rather than to patient care. The respondents maintained that they were not consulted before the RFP was issued. They were of the opinion that there was enough local talent available to adequately manage mental health in the county.

- The overriding concern of the Board of Supervisors was for UBH to bring about revenue enhancement. This meant better billing and collection of fees. UBH was also enjoined to encourage subcontractors to sign up as many eligible MediCal recipients as possible. More eligible MediCal recipients on the county roll will bring more state and federal funds to the county. More funds will allow more flexibility of health programs and will attract more capable people to carry them out. Critics of UBH felt that the company had been remiss in the fulfillment of the enrollment part, of their contract.

- Hospitals and mental health care providers claim that compensation for their services from UBH is so inadequate that they are unable to stay in business.

- The frequent down time of the UBH computerized patient information system made it difficult for care-givers to follow the patient in an up to date paperless system and to evaluate treatments.

- There were substantial deficiencies noted at the beginning of the contract. The then director of HHS found it necessary to issue a "Notice of Action" for UBH to correct the deficiencies. After the expiration of the contract time the renewal was only confined to a one-year extension until June 30, 2001.

- In an effort to get a balanced view of the above criticisms an attempt was made by the Grand Jury to get answers from a representative of UBH. UBH brought in more personnel, made managerial changes, and claimed that they were now in compliance with their contract.

D. Performance Standards

UBH administers a multitude of subcontractors supplying mental health services throughout the county. There is no uniform enforcement of performance standards in place for these subcontractors and there are not sufficient staffs available to monitor the quality of their performance. This inevitably leads to occasional substandard performance on the part of these entities.

E. Problems with MediCal

- There is unwillingness of patients to sign up for programs to which they are entitled. Receiving welfare checks represents a cultural stigma.

- Welfare to work (CalWORKS) participants are unaware of the continuing MediCal benefits to which they are entitled.

- Conditions for eligibility are complex and difficult to understand. The application forms are complicated and the process for evaluation of eligibility unduly prolonged.

- New immigrants do not want to be carried on the welfare rolls as this might affect their citizenship status in the future.

- Attitudes of some eligibility workers and social workers make the application process so arduous and inhumane by frequent delays, denials and bureaucratic obstacles that patients give up and cease trying to use these services to which they are legally entitled. Patients are also unfamiliar with the appeals process and advocacy programs at their disposal.

F. Problems with Access

- Closure of the San Luis Rey Mental Hospital in Encinitas has left the North County without an in-patient facility. Patients needing immediate care in North County must now be transported to the San Diego County Psychiatric Hospital (SDCPH). This greatly increases transportation costs to the county and inconvenience for the patients.

G. Medical Information Systems (MIS)

- There is no state-of-the-art MIS to help case managers follow individual patients from one treatment modality to another in San Diego County. There is no MIS to evaluate treatment programs, chart patient outcomes, and help to formulate future mental health policies.

- The absence of a meaningful MIS makes it difficult to write successful grant applications for financial support from federal, state or private charitable foundation sources.

- A new MIS program has been contracted to start on July 1, 2001.

H. Grant Writer

- There is no full time "grant writer" who can research all sources of available funding and write grant applications based on meaningful statistics.

I. Fragmentation, Politics and Turf Battles

- There is a division among workers in the mental health field. They do not speak with one voice. Each one of them is representing his own point of view. They maintain that their particular approach represents what is best for the patient.

- There is an underlying lack of trust between mental health workers, especially concerning their respective funding levels.

- Frequent changes in the Mental Health Director position, with ever changing directions of policies, have not helped this situation.

- Traditionally, mental disease has been thought to be different from physical disease. There is a different administration for mental and physical disease and different budgets.

- Adult mental disease is managed by a different department from that of children and adolescents. Mental disease is often associated with social problems and yet this frequent association is ignored by the organizational structure. Another department administers social services. The patient has to go to different locations to obtain the services of these different entities and has to overcome many bureaucratic obstacles.

- The so-called "dual diagnosis," a group of patients having mental disease as well as substance abuse problems, is subjected to another approach and handled by a separate department.

- Mental patients involved in the penal system and probation department are involved in yet another bureaucracy.

J. Efficiency

- There is a multitude of agencies, publicly or privately funded, each with their own bureaucratic support staff and policies trying to meet the needs of the mentally ill.

- The fragmentation into various departments leads to duplication and redundancies in support services. This increases office overhead and diverts the scarce funding into administrative expenses rather than to direct health care services.

- Each department has its own policies and documentation. The absence of a standard form and information system does not result in optimal efficiency.

K. Comprehensive Care/Team Approach

- Respondents agreed that by far the best model for delivering mental health care is the development of an integrated or "wraparound" system which involves "case management" by individuals or teams to serve all the patients' evaluated needs. These involve Physical and Mental Health Services, Social Service, Alcohol and Substance Abuse Services, Criminal Justice and Probation Department, Job Training, Family, Church and Community Support Groups, as well as Counseling and Advocacy Services. These services are connected in a seamless manner and supported by an interactive medical information system.

- The recently adopted Integrated Network Initiative is a good example of the "wraparound" case management for children. Its goals and guiding principles were developed after many years of study by the Heartbeat Project but is less extensive in scope than the original proposal.

L. Staffing

- Caseworkers are overloaded and cannot manage their cases in a comprehensive manner. They are understaffed. Inability to take on new patients causes long waiting periods for applicants.

- There are not enough county MediCal eligibility workers.

- The devotion and dedication of the workers in the mental health field is indeed remarkable. They are severely under-funded and under-

staffed. They are forced to work overtime to get the job done and are frustrated at their inability not to do more for the large number of people in need of their services.

M. Criminal System

- The average daily number of mentally ill in the County's detention centers is 800.

- The mentally ill homeless, especially if they are using drugs and alcohol inappropriately, are faced with repeated minor charges of vagrancy, public nuisance, minor theft, etc. Having no access to appropriate treatment due to lack of facilities or caseworkers they are put into detention centers. The penal system has the largest psychiatric facility in the county. The inmates are being treated at great expense to the taxpayers.

- The cost of treatment in penal institutions is very large compared to the treatment in outpatient facilities. While incarcerated, the inmates lose their MediCal payments and the associated Federal and State components such as the Supplemental Income Payments (SSI). The county cannot collect these payments to offset the cost of incarceration yet has an obligation to treat these people while they are confined.

- Upon release there is inadequate follow up. The mentally ill are returned to the street. The cycle of arrest and incarceration, the so-called revolving door cycle, continues. Because these persons do not take their medication they continue their life of homelessness and perpetration of their survival crimes (public drunkenness, shoplifting, etc.).

- The Sheriff's department has recently received a $5 million grant. This money will be used for the "Connection Project", which will help the released mentally ill with regard to follow up treatment and medication.

- The criminalization of the mentally ill is systemic in this state. San Diego County is no exception.

N. Volunteers

- Help is provided by many volunteer organizations without whose caring attitude the situation with regard to mentally ill patients and the homeless would be even more critical.

O. Governance

- Changes of policies associated with frequent changes in the leadership of the Departments of HHS and of Mental Health create a poor climate for the leadership for the mental health community to carry out its functions. At this writing the position of the Mental Health Director is still vacant.

- There has been a lack of strong advocacy on behalf of the mentally challenged to point out to policy makers that the recognition and treatment of mental illness is a matter of good Public Health. This position is strongly endorsed by the Surgeon General.

P. Board of Supervisors

- The Board of Supervisors, being an elected body, reflects the wishes of its constituents. They also have a social obligation to serve the needs of the mentally ill and are in a position to lead the community with compassion and foresight. They can also do much to change the persistent stigma attached to mental disease by supporting, and adequately funding, enlightened programs and insisting on appointing highly qualified people to implement its policies.

Q. Early Recognition and Intervention

- There is evidence that the tendency for mental disease is familial. This provides an opportunity to look for early manifestations of the disease. Intervention and treatment, before it is more advanced, will provide a better chance for the patient to become independently functional in his/her community and prevent disability and the high cost of hospitalization.

R. School System

- Respondents agree that the best opportunity to observe early dysfunctional behavior and learning disability is by the teacher, the school nurse, and the school psychologist.

- There is insufficient training of educators to recognize aberrant behavior as the very early signs of impending mental disease. School nurses are too overloaded with paperwork to exercise their professional skills to their fullest potential. Employment of clerical or volunteer staff help is prohibited by privacy considerations.

- Even though the school is thought to be the best place to spot early signs of aberrant behavior, many local school boards have not

allocated enough funds to make this early detection meaningful. They merely provide minimal space and hire counselors for a limited time.

- Some children with learning disabilities develop a feeling of isolation and frustration. This leads to acting out, antisocial behavior, crime and possible substance abuse.

- It was pointed out that by identifying the learning disability in the school environment, it could be dealt with relatively easily and inexpensively, compared to the cost to society of later criminal activity. Incarceration and hospitalization are a much greater drain on the health fund pool than early identification of a potentially serious illness.

S. Local Resources

- San Diego County has a resource of dedicated and highly trained specialists in the field of Psychiatry. Many of them are nationally recognized experts in their field and have held high advisory and policy making positions in the Federal Government. They represent a valuable resource on organizational, policy and personnel matters. The Department of Psychiatry at UCSD is one of the most respected with regard to training and research in the world. These able and dedicated professionals stand ready to lend a hand devising an optimal system of care for the mentally ill.

T. Recent Innovations and Improvements

- There is an increasing awareness on the part of law enforcement as to how to deal with the mentally disturbed patient, drug abuser, and the homeless. The Homeless Outreach Team (HOT) and the Psychiatric Emergency Response Team (PERT) are a great improvement in dealing with the homeless with sympathy and understanding but there are simply not enough of these teams to serve the need.

- The Serial Inebriate Program (SIP) has met with success in the western police division of the city to help rehabilitate chronic alcoholics and there are plans to expand the program.

SUMMARY

Comprehensive questions and interviews showed that the mental health community is made up of people of unquestioned compassion and devotion to their profession. They are working under very difficult conditions of understaffing and under-funding. They are functioning in an environment of civil denial of the existence of mental disease in our community, of persistent stigmatization of the condition and in an atmosphere of abdication of responsibility of the social

obligation for the humane treatment of persons so afflicted. There exists, however, a small and ever increasing minority of church and charitable organizations as well as many compassionate volunteers without whom the work of caring for these unfortunates would even be more taxing on the public support system.

It is the conclusion of the Grand Jury investigation that the mental health situation is critical and that many mental patients are underserved. However, the contention that it is in "shambles" could not be supported by the facts.

In this system, as indeed in any system, there is room for improvement in the administration of the Mental Health Program of San Diego County.

FINDINGS

1. A holistic approach, which considers mental health on the same continuum with physical health, is the preferred policy by many health workers in the field.

2. Funding priorities of mental health in San Diego County are only a reflection of the State's priorities according to the Little Hoover Commission report.

3. Mental Health in San Diego County is grossly under-funded compared to other counties.

4. San Diego is the 2nd largest county in California yet is 52nd out of 58 counties in mental health funding.

5. Many mentally ill patients and homeless are underserved in San Diego County.

6. The county's legislators, in Sacramento, have been unable to achieve parity with other counties with respect to mental health funding.

7. Highly qualified mental health workers are leaving the county for more rewarding opportunities.

8. The Surgeon General has advocated that mental disease be treated as part of physical disease. This concept has not yet been adopted in San Diego County.

9. The "wraparound" type of case management as in the Integrated Network Initiative for children is considered the ideal approach to the treatment of mental disease.

10. The managed care model, as represented by UBH, is resented and criticized by many respondents.

11. There are no uniformly enforced standards of performance for the various suppliers of mental health services.

12. MediCal participants bring additional State and Federal dollars to the county.

13. There are cultural and language reasons as well as citizenship concerns for eligible persons not to sign up for MediCal.

14. The application form is complex and the eligibility process is unduly prolonged.

15. Many applications are denied without appeal.

16. New immigrants are not familiar with the existing appeals and advocacy processes.

17. Many persons are unaware that they may be eligible for MediCal.

18. There are no inpatient facilities in North County since the San Luis Rey hospital in Encinitas closed.

19. There is not, at present, a uniform, up-to-date, and sophisticated Medical Information System in place which all departments and subcontractors of the mental health systems can access.

20. It is difficult to obtain grants if no meaningful statistics can be submitted.

21. The resources of the Department of Health (HHS) are so stretched that they do not have a person to research and apply for available grants.

22. The fragmentation of the Department of Health (HHS) leads to increase in administrative overhead, duplication and turf battles.

23. There are not enough caseworkers to handle the load of mentally ill persons.

24. Categorical funds would be better spent if the categories were wavered and if they were all pooled.

25. There are not enough MediCal eligibility workers.

26. The mentally ill are sometimes put into penal institutions when there are no other facilities available for treatment. This is a great injustice to them.

27. The Penal System employs a large group of psychiatrists at great expense to the county.

28. The mental health situation would be much worse without the assistance of many volunteers and private charitable organizations.

29. Vacancies in the positions of leadership in the Departments of Health (HHS) and mental health lead to lack of consistent policies and loss of advocacy for improvement.

30. There is a stigma in the public mind concerning mental health.

31. Mental health does not have a large enough constituency and advocacy role in the seats of power and in the area of policy formulation.

32. Since mental disease tends to run in families, schools are in a position to detect early aberrant behavior in children.

33. The early detection and treatment of mental disease is more cost effective than later intervention in more serious disease, which requires hospitalization or incarceration.

34. School nurses are too overloaded with clerical work to be able to fully utilize their expertise.

35. Local school boards do not understand the importance of early detection and do not sufficiently fund counselors, nurses, and psychologists.

36. There is a resource of highly competent mental health professionals (psychiatrists) who could be consulted if the decision is made to institute a not for profit system for administering mental health.

37. The mental health situation in San Diego County is critical but by no means in shambles.

RECOMMENDATIONS

That the San Diego County Board of Supervisors:

01-23: Urge local representatives to the State legislature and lobbyists to aggressively apply for all available funds to bring San Diego County to

parity with other counties to expand services and provide more flexible programs.

01-24: Consider bringing the administration of mental health back under the Department of Health and Human Services (HHS).

01-25: Consider a contract with a not-for-profit corporation, which has demonstrated success in other parts of the country. The excellent connections of the Department of Psychiatry at UCSD could be utilized to find such an entity.

01-26: Increase compensation of mental health providers to prevent drain of qualified people out of the county.

01-27: Give mental health a higher funding priority.

01-28: Make more regional facilities available to mentally ill and homeless to alleviate the burden and cost to the penal system.

01-29: Provide better follow-up for those released from penal institutions to prevent recidivism.

01-30: Open an inpatient and outpatient facility in North County to provide easier access for mentally ill patients.

01-31: Increase the number of PERT and HOT teams.

01-32: Expand the SIP program.

01-33: Take a leadership role in sponsoring educational programs to alleviate the stigma of mental disease and to acquaint the public with the extent of the problem.

01-34: Encourage the San Diego Medical Society to initiate a campaign to publicize the extent of the mental disease problem, the importance of early recognition and the possibility of successful treatment.

01-35: To enlist the expertise of local physicians to help formulate policy decisions to solve the problems of the mentally ill in the county under a managed care model which is fair both to the provider and the recipient of care.

01-36: Make the use of the expertise of the local psychiatric community, including staff at UCSD, in formulating policies and finding qualified and dedicated personnel.

That the San Diego County Department of Health and Human Services:

01-37: Employ a grant writer. This position could be a consultant with no benefits. Seed money to be obtained from a foundation. After 2 years the position could be funded from the additional monies received.

01-38: Obtain waivers for the spending of categorical funds and place them into a pool, which does not discriminate between physical health, mental health, substance abuse, homelessness, and social services.

01-39: Assure the various departments that under pooling they would receive no less funding than before, and that by effecting economies of scale in office overhead, they would probably receive an increase in their portion of the pool.

01-40: Encourage a team approach to the case management of all mentally ill patients and encourage the help of family and community resources.

01-41: Set performance standards for suppliers of mental health services and enforce them, regardless of political considerations.

01-42: Employ more caseworkers.

01-43: Employ more MediCal eligibility workers.

01-44: Improve enrollment of eligible new immigrants and ethnic minorities into MediCal, SSI, and other available programs.

01-45: Increase educational efforts to acquaint new immigrants, persons with physical and mental disability and CalWORKS recipients with programs and services for which they may be eligible.

01-46: Disseminate information on the availability of the appeals process and of advocacy programs.

01-47: Increase efficiency by merging departments and eliminating administrative costs and duplication after consultation with health care workers.

01-48: Encourage inter-departmental team case management by closer cooperation between individuals or teams of case managers. This paradigm is referred to as integrated or wraparound management.

That the San Diego County Office of Education:

01-49: Emphasize early detection and treatment at the school level to prevent a common progression to more serious disease, which is more difficult to treat and entails a higher social cost.

01-50: Encourage local school boards to allot more funds for the early detection of mental disease by teachers, counselors, nurses, and psychologists.

01-51: Encourage local school boards to use clerical assistance (volunteers) to school nurses so that nurses can use their professional skills more effectively to diagnose early mental disease.

REQUIREMENTS AND INSTRUCTIONS

The California Penal Code §933(c) requires any public agency which the grand jury has reviewed, and about which it has issued a final report, to comment to the Presiding Judge of the Superior Court on the findings and recommendations pertaining to matters under the control of the agency. *Such comments shall be submitted no later than 90 days after the grand jury submits its report to the public agency.* Also, every ELECTED county officer or agency head for which the grand jury has responsibility shall comment on the findings and recommendations pertaining to matters under the control of that county officer or agency head, as well as any agency or agencies which that officer or agency head supervises or controls. *Such comment shall be made within 60 days to the Presiding Judge of the Superior Court with an information copy sent to the Board of Supervisors.*

Furthermore, California Penal Code §933.05(a), (b), (c), details, as follows, the manner in which such comment(s) are to be made:

(a) As to each grand jury finding, the responding person or entity shall indicate one of the following:
    (1) The respondent agrees with the finding
    (2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

(b) As to each grand jury recommendation, the responding person or entity shall report one of the following actions:
    (1) The recommendation has been implemented, with a summary regarding the implemented action.
    (2) The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
    (3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or

study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the grand jury report.

(4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

(c) If a finding or recommendation of the grand jury addresses budgetary or personnel matters of a county agency or department headed by an elected officer, both the agency or department head and the Board of Supervisors shall respond if requested by the grand jury, but the response of the Board of Supervisors shall address only those budgetary or personnel matters over which it has some decision making authority. The response of the elected agency or department head shall address all aspects of the findings or recommendations affecting his or her agency or department.

Comments to the Presiding Judge of the Superior Court in compliance with the Penal Code §933.05 are required from the:

San Diego County Board of Supervisors	**Recommendations: 01-23 through 01-36**
San Diego County Department of Health and Human Services	**Recommendations: 01-37 through 01-48**
San Diego County Office of Education	**Recommendations: 01-49 through 01-51**